APPENDIX D

PUBLIC MENTAL HEALTH MANUAL

MICHIGAN DEPARTMENT OF MENTAL HEALTH

CHAPTER	SECTION	Volume	Sec.	Sub.
PROGRAM AND SERVICES ADMINISTRATION	CLIENT SERVICES MANAGEMENT	IV	001	0001
SUBJECT: ELIGIBILITY FOR CMH CLIENT SERVICES MANAGEMENT FOR ADULTS IN OR REQUESTING DEPENDENT CARE		Chapter: H	Date: 5-18-83	Page: 1

Approved:

Technical Approval By:

I. SUMMARY:

The content of this guideline establishes minimum standards to assist community mental health (CMH) and Department of Social Services (DSS) staff in determining which agency shall be responsible for client services management, placement and follow-up of adults currently in non-specialized dependent care or seeking dependent care. The establishment of this guideline and the standards and policies herein is in keeping with the 1979-80 DSS/CMH/DMH Adult Community Placement Agreement. Its implementation is intended to regularize, to the extent possible, communication and referrals between the two major public systems that administer those programs and services required by some developmentally disabled and formerly mentally ill adults if they are to remain in the community. Without ready access to the resources of both systems, the adults in question may experience crisis, go unserved, be inappropriately served or be unnecessarily institutionalized. While referrals on behalf of anyone in need may be made at any time to DSS and/or CMH, this guideline addresses specific populations and suggests time intervals and major variables to assist in the referral process, particularly when referring to CMH. Clearly, many of the adults who require ongoing placement and follow-up services are active recipients of community mental health services. The objective of these standards is to bring those adults most at risk of institutionalization to the attention of the public mental health system so they may be given priority for client services management (CSM) and follow-up service. Lastly, these entry standards do not preclude CMH from serving individuals who exceed these standards, nor do they relate to any other entry/exit criteria utilized by CMH.

II. APPLICATION:

A. Regional psychiatric hospitals operated by the Department of Mental Health (DMH).

B. Regional centers for developmental disabilities operated by the Department of Mental Health.

C. Community mental health boards as specified in their contracts with the Department of Mental Health and any state facility subcontracts negotiated as part of the master contract.

III. POLICY:

A. FOR ONE YEAR FOLLOWING THEIR EXIT FROM A STATE HOSPITAL OR CENTER, REGARDLESS OF WHETHER SUCH PERSONS MEET THE ENTRY STANDARDS ENUNCIATED IN THIS GUIDELINE, CMH (DMH) SHALL BE RESPONSIBLE FOR PLACEMENT AND FOLLOW-UP OF ALL ADULTS WHO CONSENT TO AND ENTER SERVICE PROGRAMS WHERE CSM IS PROVIDED. THE ONLY EXCEPTION WOULD BE THE INDIVIDUAL FOR WHOM A SECOND CERTIFICATION CANNOT BE SECURED FROM A DMH PSYCHIATRIST LEADING TO IMMEDIATE DISCHARGE.

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III. POLICY: (Cont.)

B. WHETHER SERVED BY CMH OR DSS, WRITTEN INFORMED CONSENT IS REQUIRED; THUS, AN INDIVIDUAL WHO DECLINES PUBLIC MENTAL HEALTH SERVICES MUST DO SO IN WRITING BEFORE AN APPLICATION FOR DSS SERVICES IS PROCESSED.

C. CMH (DMH) SHALL USE THE ENTRY STANDARDS ENUNCIATED IN THIS GUIDELINE AS INDICATORS IN DETERMINING ELIGIBILITY FOR ENTRY INTO THE CSM SYSTEM FOR PURPOSES OF PLACEMENT AND FOLLOW-UP OF ALL ADULTS DEFINED IN THE DSS/DMH/CMH AGREEMENT AS NEVER OR FORMERLY INSTITUTIONALIZED WHO CONSENT TO TRANSFER FROM DSS TO THE PUBLIC MENTAL HEALTH SYSTEM.

D. THE GLOBAL ASSESSMENT SCALE (GAS), REFERRED TO IN THE STANDARDS, IS BUT ONE INDICATOR TO BE UTILIZED WHEN DETERMINING NEED FOR SERVICES. THE INDIVIDUAL'S CURRENT GAS SCORE IS A TRIGGER TO ACTIVATE A REFERRAL TO CMH OR DSS.

E. CMH BOARDS MAY, AT THEIR DISCRETION, PROVIDE CSM FOR INDIVIDUALS WHOSE FUNCTIONING EXCEEDS THESE ENTRY STANDARDS BUT NOT IF IT PRECLUDES PROVIDING NEEDED SERVICES TO THE MORE SEVERELY IMPAIRED.

F. BY VIRTUE OF THE AGREEMENT, ADULTS WHO APPEAR TO BE ELIGIBLE FOR CMH CLIENT SERVICES MANAGEMENT BASED ON THE STANDARDS HEREIN ARE:

1. NEVER INSTITUTIONALIZED PERSONS REQUESTING DEPENDENT CARE FOR THE FIRST TIME;

2. NEVER INSTITUTIONALIZED ADULT FOSTER CARE RESIDENTS WHO WERE IN DEPENDENT CARE PRIOR TO FY 81-82; AND

3. FORMERLY INSTITUTIONALIZED RESIDENTS OF NON-SPECIALIZED ADULT FOSTER CARE HOMES WHO EXITED A DMH INSTITUTION AT LEAST ONE YEAR PRIOR TO THE DATE OF THE REFERRAL.

G. REFERRALS BY CMH AND DSS WILL BE MADE ON AN INDIVIDUAL BASIS AS STAFF PERFORM THEIR QUARTERLY IN-PERSON CONTACTS WHICH ARE REQUIRED TO VERIFY THE RESIDENT'S ELIGIBILITY FOR TITLE XIX PERSONAL CARE PAYMENTS. REFERRALS MAY, OF COURSE, BE MADE AT ANY OTHER TIME WHEN DEEMED APPROPRIATE.

H. THE PARTICIPATION OF THE INDIVIDUAL IS ESSENTIAL. CONSENT OF THE INDIVIDUAL OR THE EMPOWERED GUARDIAN SHALL BE SECURED IN WRITING. THIS CONSENT SHALL EXPLICITY INCLUDE COOPERATION IN THE PURSUIT OF THIRD-PARTY PAYMENTS FOR SERVICES.

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III. POLICY: (Cont.)

I. IN THE EVENT THE INDIVIDUAL REFUSES TO CONSENT TO RECEIVE SERVICES FROM CMH, DSS WILL ACT AS THE RESPONSIBLE AGENCY AND CMH WILL PROVIDE TECHNICAL ASSISTANCE AND CONSULTATION AS REQUIRED.

J. CMH WILL RESPOND TO EACH REFERRAL WITHIN NO LESS THAN 30 DAYS. IF THE INDIVIDUAL REMAINS WITH DSS AS THE RESPONSIBLE AGENCY, CMH WILL PROVIDE WRITTEN DOCUMENTATION INDICATING WHY THE REFERRAL WAS NOT ACCEPTED AND ANY RECOMMENDATIONS THEY MAY HAVE FOR PROVIDING SERVICE TO THE INDIVIDUAL.

K. ENTRY INTO THE CMH CLIENT SERVICES MANAGEMENT SYSTEM SHALL OCCUR ALONG THE FOLLOWING CONTINUUM:

1. REFERRAL FOR CSM NOT ACCEPTED; DSS CONTINUES TO BE RESPONSIBLE FOR PLACEMENT AND FOLLOW-UP;

2. REFERRAL FOR CSM NOT ACCEPTED; RECIPIENT TO RECEIVE SERVICE VIA INVOLVEMENT IN ONE OR MORE PROGRAM ELEMENTS, RESPONSIBILITY FOR PLACEMENT AND FOLLOW-UP REMAINS WITH DSS; AND

3. REFERRAL FOR CSM ACCEPTED; CMH ASSUMES RESPONSIBILITY FOR CSM, PLACEMENT AND FOLLOW-UP. IN ADULT FOSTER CARE, THIS MEANS BEING THE RESPONSIBLE AGENCY AS DEFINED IN P.A. 218 OF 1979.

L. IF CMH BECOMES RESPONSIBLE FOR PLACEMENT AND FOLLOW-UP (AS DEFINED IN P.A. 218 OF 1979), THAT RESPONSIBILITY SHALL CONTINUE FOR NO LESS THAN SIX MONTHS AND SHALL INCLUDE THE PURSUANCE OF ALL THIRD-PARTY BENEFITS FOR WHICH A RECIPIENT MAY BE ENTITLED.

M. BASED ON THE STANDARDS BELOW IN V., EITHER PARTY MAY AT ANYTIME REQUEST A CONFERENCE TO DISCUSS THE TRANSFER OF AN INDIVIDUAL. INFORMATION GERMANE TO THIS PURPOSE MAY BE SHARED WITHOUT BREACHING CONFIDENTIALITY. IN THE EVENT OF DISAGREEMENT OVER WHICH AGENCY SHOULD PROVIDE CSM, RESPECTIVE DSS ZONE AND DMH AREA MANAGEMENT ARE TO BE CONSULTED FOR ASSISTANCE.

N. THE DETERMINATION THAT AN INDIVIDUAL IS IN NEED OF MENTAL HEALTH SERVICES AND THE DECISION TO PROVIDE SAME IS CLEARLY A CLINICAL DECISION THAT CAN BE MADE ONLY BY THE PUBLIC MENTAL HEALTH SYSTEM.

IV. DEFINITIONS:

None

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V. STANDARDS:

A. Adults accepted for CSM by a CMH agency for purposes of placement and follow-up services shall be:

1. developmentally disabled in accordance with Chapter 5, Section 500h of P.A. 258 of 1974, as amended, and display behavior requiring some physical assistance in self-care skills, or supervision due to periodic behavioral problems or physical limitations (a level forty or below on the DD Global Assessment Scale, see Exhibit A); or

2. display symptomology or functional impairments that would cause most clinicians to think the individual obviously requires treatment or attention; e.g., suicidal preoccupation or gesture, severe obsessional rituals, frequent anxiety attacks, mild but definite manic syndrome (a level fifty or below on the MI Adult Global Assessment Scale, see Exhibit B).

B. Referrals shall address the following in addition to the current Global Assessment Scale:

1. Strengths and limitations of the individual, not reflected in GAS score, that may impact on the person's capacity to remain in the community.

2. The role of the family in supporting or interferring with the individual's mental health treatment plan.

3. The capacity of the provider to assist in furthering the individual's mental health treatment plan.

4. Any other information deemed important to help determine whether the individual should receive placement and follow-up services from CMH or DSS.

VI. REFERENCES AND LEGAL AUTHORITY:

A. Public Act 218 of 1979.

B. Section 116 of Public Act 258 of 1974, as amended, being MCL 330.1116, Mental Health Code.

VII. EXHIBITS:

A. Global Assessment Scale DD.

B. Global Assessment Scale MI Adult.

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EXHIBIT A

Global Assessment Scale for Developmentally Disabled

Rate the client's lowest level of functioning on the DD Matrix scale. The rating is based on observed and reported functioning for the week prior to the last contact. Rate actual functioning independent of diagnosis, treatment, or perceived potential.

100 Independent in self-care skills and advanced daily living skills, problems
91 never seem to get out of hand, participates in many activities.

90 Independent in self-care skills and advanced daily living skills; transient
| symptoms, every day problems occasionally get out of hand, without impair-
81 ment of functioning.

80 Independent in self-care skills, some advanced daily living skills, minimal
71 disruption of functions due to transient emotional reaction.

70 Independent in self-care skills, but may require very minimal supervision.
| Some physical assistance may be required, but only if due to physical
| handicap. Generally, no behavioral problems.
| or
| May have some advanced daily living skills, but has intermittent socially
61 inappropriate behaviors which require some intervention.

60 Can carry out self-care skills, but requires supervision. May require ver-
| bal prompts in self-care areas, but will only require minimal physical
| assistance due to physical handicap or behavior problems which require
51 intervention may occur, but they are only intermittent.

50 Requires verbal and physical prompts for self-care. No ongoing pattern of
| behavior problems that require intervention. Generally willing to par-
| ticipate in activities; however, behavior problems which require interven-
41 tion may occur.

40 Requires some physical assistance in self-care skills, can participate in
| activities with supervision for periodic behavioral problems or physical
| limitations.
| or
| May have self-care skills with intermittent serious behavior problems
31 (assaultive or abusive).

30 Requires some physical assistance in self-care, with some willingness to
| participate, but requires regular intervention due to behavioral problems.
| or
| Requires extensive physical assistance due to handicap, but demonstrates
21 willingness to participate and carry out tasks within physical limitations.

20 Requires physical assistance in self-care, is often unwilling to
| participate.
| or
| Requires regular intervention due to serious behavior problems (assaultive
11 or self-abusive).

10 Requires nearly total physical care.
| or
| Requires constant supervision due to regular need to intervene due to
1 serious behaviors (assaultive or self-abusive).

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EXHIBIT B

MI Adult
Global Assessment Scale (GAS)
Robert L. Spitzer, M.D., Miriam Gibbon, M.S.W., Jean Endicott, Ph.D.

Rate the client's lowest level of functioning on a hypothetical continuum of mental health-illness. The rating is based on observed and reported functioning for the week prior to the last contact. Rate actual functioning independent of diagnosis or treatment.

100 | 91 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his warmth and integrity. No symptoms.

90 | 81 Good functioning in all areas, many interests, socially effective, generally satisfied with life. There may or may not be transient symptoms and "every day" worries that only occasionally get out of hand.

80 | 71 No more than slight impairment in functioning, varying degrees of "every day" worries and problems that sometimes get out of hand. Minimal symptoms may or may not be present.

70 | 61 Some mild symptoms (e.g., depressive mood and mild insomnia) OR some difficulty in several areas of functioning, but generally functioning pretty well, has some meaningful interpersonal relationships and most untrained people would not consider him "sick".

60 | 51 Moderate symptoms OR generally functioning with some difficulty (e.g., few friends and flat affect, depressed mood and pathological self-doubt, euphoric mood and pressure of speech, moderately severe antisocial behavior).

50 | 41 Any serious symptomatology or impairment in functioning that most clinicians would think obviously requires treatment or attention (e.g., suicidal preoccupation or gesture, severe obsessional rituals, frequent anxiety attacks, serious antisocial behavior, compulsive drinking, mild but definite manic syndrome).

40 | 31 Major impairment in several areas, such as work, family relations, judgment, thinking or mood (e.g., depressed woman avoids friends, neglects family, unable to do housework), OR some impairment in reality testing or communication (e.g., speech is at times obscure, illogical or irrelevant), or single suicide attempt.

30 | 21 Unable to function in almost all areas (e.g., stays in bed all day) OR behavior is considerably influenced by either delusions or hallucinations OR serious impairment in communication (e.g., sometimes incoherent or unresponsive) or judgment (e.g., acts grossly inappropriately).

20 | 11 Needs some supervision to prevent hurting self or others, or to maintain personal hygiene (e.g., repeated suicide attempts, frequently violent, manic excitement, smears feces), OR gross impairment in communication (e.g., largely incoherent or mute).

10 | 1 Needs constant supervision for several days to prevent hurting self or others (e.g., requires an intensive care unit with special observation by staff), makes no attempt to maintain minimal personal hygiene, or serious suicide act with clear intent and expectation of death.

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